# PHILANTHROPIC OPPORTUNITIES IN CORRECTIONAL HEALTH CARE

**Prepared for the**
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## EXECUTIVE SUMMARY

Jails (both local jails and regional houses of corrections) and prisons represent one of the largest target populations for public health services in America. Yet, most states tend to take a minimalist approach to expending tax dollars for correctional health care, especially where health care for the broader population is inadequate. Only recently have correctional facilities and policy makers begun to shift back to the rehabilitation and community connectivity orientation of the 1960s and 1970s. In substantial ways, correctional health care programs are an extension of local public health systems. As such, they are important sites for improving the overall health and well-being of communities.

This report, ***Philanthropic Opportunities in Correctional Health Care,*** commissioned by the Jacob and Valeria Langeloth Foundation, examines some of the challenges and the lessons learned and best practices exhibited by state and local collaborations. This report is intended as a preliminary guide to future directions and opportunities for private foundations as the field of correctional health care grows and evolves. The specific recommendations to foundations include supporting: access to Medicaid funds; data collection, research and evaluation; capacity building; policy advocacy and system reform; training and technical assistance; curricula development; support services to families of offenders; gender-specific health care; and convening stakeholders.

# INTRODUCTION

The 1971 uprisings at Attica Correctional Facility in rural New York brought national attention to poor conditions and human rights abuses within prisons and jails. While *Estelle v. Gamble*, U.S. Supreme Court (1976), established the constitutional right of prisoners to adequate medical care, most states have tended to take a minimalist approach to expending tax dollars for correctional health care, especially where health care for the broader population is inadequate. Health care for youth in the juvenile justice system generates some public sympathy. Yet, even in states where prisons are perceived to have a rehabilitative function, health care tends to cease once an inmate is released. Only recently has there been a shift back to the rehabilitation and community connectivity orientation of the 1960s and 1970s, particularly as respected policy research institutions such as the Urban Institute have documented the high long-term social and economic costs of prisoner re-entry.

A June 2003 report by The National Institute of Corrections (NIC) Information Center indicates that public health agencies and prisons have a mutual interest in addressing inmates' medical and mental health problems. In many ways, correctional health care programs are an extension of local public health systems. Inmates in jails (both pre-trial local jails and regional houses of corrections for short sentences) and prisons represent one of the largest target populations for public health services in America. Because inmates have disproportionately higher rates of infectious diseases and mental illness than the general population, health care costs constitute a significant portion of state corrections agencies' budgets.

The eventual re-entry of inmates to their communities forces public health agencies to address issues of continuity of care for newly released persons, especially as a guard against spreading communicable diseases in the community. This is true particularly among African American communities, where

in the years between 1982 and 1996, the likelihood of HIV-AIDS infection was nine times greater than in the white community due largely to disproportionately high rates of African American incarceration (366 per 100,000 whites; 759 per 100,000 Latinos; 2,209 per 100,000 African Americans) and more frequent rotations between community and jails and prisons.

Public health agencies often have more resources to prevent disease transmission than do correctional health facilities. With these realizations, states have encouraged a growing number of corrections-public health collaborations. By 2003 most state departments of corrections reported that they are engaged in collaborative work with public health agencies. Perhaps the most interesting finding in a survey of large jails was that the coordinated correctional health care programs required no significant additional monies. By working collaboratively, the agencies were often able to identify existing resources to solve the identified problems. This model – described in more detail in later sections – is referred to as the public health, or community-based, model of correctional health care.

This report, ***Philanthropic Opportunities in Correctional Health Care,*** examines some of the lessons learned and best practices exhibited by state and local collaborations as a guide for future directions and opportunities for private foundations.

# OVERVIEW OF SALIENT ISSUES IN CORRECTIONAL HEALTHCARE

## National Profile

The United States has the highest incarceration rate in the world, with 1 in 32 U.S. adults under some form of correctional supervision. Incarcerated individuals experience disproportionately higher rates of infectious and chronic diseases, substance abuse, mental illness and trauma than the general population. Inmates are also overwhelmingly poorer, less educated and more likely to be persons of color than the general population. The nation's prison population grew 1.9% in 2004, reaching two million inmates. Nearly five percent of all inmates were housed in local jails. The population of both prisons and jails is aging with 38% aged 35 or older in 2002, up from 32% in 1996, creating more need for long-term attention to chronic illnesses and geriatric conditions.

No single health care system can work for all people who are incarcerated, partly because it depends on where they are imprisoned. Jails are short-term facilities, with stays usually between 12-30 months. They tend to be run by city or county authorities. Approximately 40% of the people in jail at any time are awaiting arraignment, 20% are serving sentences, and 40% have returned because of a technical violation of the term of probation or parole. Prisons are state- or federally-run facilities where the average stay is two years. As a result, correctional health care systems vary from place to place and within systems.

In addition to caring for persons while they are incarcerated, prisoner re-entry is important because the number of people released from prison has increased by 350% over last 20 years with 650,000 released annually from prisons and 7 million released from jails each year. Overall, the nation's parole population grew 20,230 in 2004, or 2.7%, more than twice the average annual increase of 1.3% since 1995. The number of adult men and women in the United States who were being supervised on probation or parole at the end of 2004 reached a new high of 4,916,480. These people are released with complex needs, including substance

abuse, parenting responsibilities, poor education, poor earnings, physical or mental disability, and no community supervision. In addition, they are released into communities that are ill-equipped to help them succeed because the communities are often populated by people of color with few resources for serving the substance abusers or people in poor physical or mental health.

## New York State

It is particularly useful to focus on the state of New York, in terms of the size of inmate population, spending, health care services offered (including differences between state and New York City), women in prison, mental health issues, and the youth inmate population.

Size of Inmate Population: The size of the inmate population exceeds 71,000 prisoners in the more than 70 correctional facilities throughout the state of New York, representing an increase in incarcerated persons of over 50,000 in the last 30 years. On any given day, about 70% of New York City's inmates are pre-trial detainees who have been charged but not convicted. As is true nationally, a significant number of New York inmates suffer from serious illnesses, including a high prevalence of HIV/AIDS, tuberculosis, and Hepatitis-C.

Spending on Correctional Health Care: According to the NY State Department of Corrections, spending on correctional health has increased by 63% since 1995, as the inmate population has declined by 9% from a high in 1999. AIDS deaths have dropped by 94%, and TB cases have dropped by 88%. New York is one of only three states (AZ, CA, and NY) that engage in multi-level collaborations between correctional and health facilities involving two or more partners at the state, county, and/or federal levels.

Health Services Offered: A 2003 survey of the health services offered by all fifty states, Canada, the U.S. Bureau of Prisons, and three major cities (New York City, Chicago, and Philadelphia), showed that a majority of corrections agencies contract with a private provider for all or some aspects of inmate health care

services. In New York City the Department of Health and Mental Hygiene pays an outside contractor to provide all jail inmate health care services. The agency is a major partner in that it oversees the work of the private provider and provides the Department of Corrections with updates and health alerts.

While participants in the survey state that, "[New York] corrections is doing public health in our community. Dealing with public health issues while inmates are incarcerated is more efficient than finding them in the community later," there are clearly major gaps in service.

Women: Female inmates are the fastest growing segment of the prison population. From 1973 to 2004, the number of women in New York State prisons increased by approximately 760% – a rate of growth over one and a half times the rate for men. Nationally, nearly 23% of women inmates nationwide are identified as mentally ill compared to nearly 16% for men in 2003. However, in New York State, at least 30% of women under custody are either currently or potentially in need of psychiatric treatment, as compared to 11% of male inmates. Nearly 15% of women in New York's prisons are known to be HIV+, a rate of infection almost double the rate for male inmates (7.8%), and more than 100 times the rate in the general public(.14%). Female inmates also have high rates of Hepatitis-C and tuberculosis. Other health needs include the 85% of women in prison who report having a substance abuse problem prior to arrest.

Mental Health Issues: Compounding the problems is the increased practice of incarcerating individuals with mental health issues, particularly in the use of disciplinary (solitary) confinement. According to the Correctional Association of New York, the state leads the nation in the use of disciplinary confinement (6.7% of prisoners compared with 2.6% of prisoners national average). While only 11% of New York's prisoners have mental illness, near one-fourth of inmates in disciplinary segregation are mentally ill. These conditions often lead to long prison stays, a high rate of self-injury among inmates, and insufficient care for prisoners with mental illness.

Youth: Though the local correctional population of New York consists predominately of young males ranging from 18–30 years of age, an increasingly high number of teens are being sent to adult correctional facilities. Limited financial and medical resources make it difficult to provide the special health needs of this population. Among older men, the cost of health care for geriatric inmates is triple that of younger inmates due to chronic illness.

# SHORT-TERM AND LONG-TERM CHALLENGES

## National Challenges

One of the greatest barriers to persons in correctional facilities receiving health care is the same barrier facing the general population – lack of access to health insurance coverage. Currently, states have the option of suspending or terminating Medicaid benefits while a person is confined to a public institution. However, many states go as far as terminating the *eligibility* of persons based on their status as inmates. Perhaps states fear –incorrectly -- they are violating federal laws about the availability and use of state funds. The availability of Medicaid funds has tremendous implications for delivering continuity of care. This affects not only those with common chronic diseases, but those in need of mental health services and those receiving substance abuse treatment.

Other challenges include:

**Data Collection, Research and Evaluation** - Correctional health care as a field recognizes the importance of promoting evidence-based programs and policies, but it suffers from poor data collection systems. Few systems have electronic medical records, and most paper record systems are only marginally useful. Corrections as a whole is reportedly well behind the information technology curve when compared with other fields, with the health care components bearing the most harmful results of these deficiencies. Not only do

information and outcomes vary due to inconsistent reporting methods, but the custody and medical sides are often reluctant to share data with each other. This problem is particularly acute for those who work with mentally ill inmates.

Increasing support for research and evaluation within the correctional health care field is critical. The ability to effectively measure outcomes and impact of programs is substantially hindered by the generally poor quality of data collection, management information systems, tracking systems and the large variations in data systems found across correctional systems. In addition to affecting the ability to deliver continuity of care to inmates, poor data management systems limit the application of outcomes-based research models that are vital to making the case to funders and policy makers.

**The Lack of Federal Guidelines** - Unlike hospitals, which have to be accredited, the health care systems in jails and prisons do not fall under federal guidelines. The National Commission on Correctional Health Care (NCCHC) is the standards setting body for the field, but compliance is voluntary. Courts have mandated that some jails comply with NCCHC standards, but participation is generally low; only 10 percent of U.S. prisons and jails are NCCHC-accredited. The American Public Health Association (APHA) also has standards for: treatment of prisoners in segregation; care of adolescent prisoners; human rights in prison; mental health care; sexuality in prison; and infectious diseases (AIDS, Hepatitis-C). The Joint Commission on Accreditation of Healthcare Organizations also has established standards for correctional health care. All but the APHA have accrediting programs. However, shrinking correctional budgets and escalating health care costs make the road to accreditation difficult, particularly in the face of public biases against prisoners.

Some of the more pressing needs identified include: contracts that allow access to medical specialists; access to emergency services; access to needed medications; monitoring and accountability to ensure quality of care; appropriate treatment for the mentally ill; and mortality reviews. Additionally,

ethical and operational standards to guide the integration of correctional health care and community health services would be invaluable.

**Staff Turnover** - The quality of medical providers in jails and prisons has improved substantially over the last 30 years. In the past, providers were often retired clinicians and/or of questionable qualification. Largely as a result of court challenges to poor health treatment received by inmates, many of the less capable practitioners have retired. New doctors tend to be board certified and perhaps bring a stronger sense of commitment to their work. Nonetheless, constraints that affect staff retention remain. Medical staffs are generally poorly equipped to withstand the operational and political interference from non-medical staff that affects the delivery of care. They face budget constraints and security limitations that frustrate the continuity of care. Nor are they able to make adequately the case for increased funding within the correctional bureaucracy. Staff turnover has also pushed many systems to contract with private providers. While jails tend to be a bit more stable than prisons, staff retention remains an issue.

**Reducing Infectious Diseases** - HIV/AIDS, tuberculosis, and Hepatitis-C present serious individual and public health challenges for the inmate population. Treatments are available, but at a cost. HIV treatment costs $12,000-$15,000 annually, while Hepatitis-C treatments cost $15,000 over a 6-12 month period.

**Marginal Involvement of Hospitals** - Hospitals generally are not focusing on the health implications of inadequate correctional health care systems in any comprehensive or strategic way. Although they may appreciate the benefits of good discharge planning in their ability to promote continuity of care, they are not reported to be very active in wider community-based health networks. Doctors and other medical practitioners specializing in particular diseases or illnesses, on the other hand, may be much more aware of the health implications of prisoner re-entry and more connected to community-wide initiatives. Because hospitals have fully developed infrastructures, training budgets, and offer

critically needed resources it is important to establish pathways to connect released inmates to the services they offer.

**Transition Planning and Continuity of Care** - Jails primarily house people who are not yet convicted of a crime and those with sentences of one year or less. Incarcerations typically average two months (and can be as little as 24-48 hours). Once a person is convicted he or she is sent to a state or federal prison, where the median length of incarceration is 2.5 years. Many of those serving short sentences are kept in jail rather than being sent to prison. The approach to health care changes depending on where within the system an inmate is and how he or she is moved within the broader system, and needs to be tailored accordingly. The lack of set release dates for those who are jailed makes it much harder to do discharge planning or provide continuity of care. From a public health perspective, jails have more of a community setting, whereas prisons are often characterized as correctional warehouses that are geographically removed from most prisoners' communities. However, prisons allow for better continuity of care because inmates are there for longer periods and release dates are known. This allows for better pre-release planning -- developing health care plans, establishing community contacts, finding housing, etc.

**Lack of Orientation Programs** - Few systems have adequate orientation programs for new health care managers and other correctional health care providers. Particularly lacking is guidance on how to work with correctional personnel and how to mediate their role as patient advocate and their responsibility for maintaining the security of the prison. Additionally, medical providers are poorly equipped to advocate for better budgets. Better direction in these areas would ultimately result in reduced staff turnover as well as improved care. Additionally, there are issues related to the cultural competency of providers to provide care to people of different racial and ethnic backgrounds. This is particularly important for those working in prisons, which tend to be in predominantly white, isolated rural areas. Finally, an emerging issue concerns the ethical expectations

of medical staff in the face of executions and abuse of prisoners; beyond the Hippocratic Oath, codes of conduct need to be developed and widely shared.

**Addressing Basic Needs** - Correctional health care issues are rather narrow and clear-cut in terms of the public health implications of substandard care. The discussion widens when put in the context of community health care and how health and health care determine what happens to a community and its residents. While disease management is clearly an important component, alone it is not enough. The barriers that preclude vulnerable populations from maintaining good health must be addressed: basic needs such as food, shelter, education, and job opportunities. Correctional health care policy is often overshadowed by the need for programs and policies that address immediate needs for housing, jobs, and other support services.

## New York State Challenges

In 2000, the Correctional Association of New York found that the Department of Correctional Services (DOCS) deserved recognition for reducing the number of annual AIDS-related deaths by 85% in the three years between 1995 and 1998, for increasing substantially the proportion of the operating budget dedicated to HIV/AIDS care, for enabling 25,000 inmates to receive anonymous HIV tests and counseling, for aggressively reducing the number of inmates with active tuberculosis infection from 1994 to1998, for opening facilities for inmates with terminal illnesses or serious, chronic medical conditions, including a range of outpatient specialty clinics for inmates from nearby prisons, and for developing model health care procedures.

Yet, the systemic problems facing New York require significant budgetary changes, union negotiation and legislative oversight to overcome. For example, prison health care workers are not regulated by the New York State Department of Health and are accountable only to prison authorities. While the quality of medical providers has improved nationally over the last 30 years, many physicians lack experience as general practitioners or training in primary care.

With such poor skills, the doctors are paid non-competitive salaries, exacerbating the challenges of recruiting and retaining medical personnel.

Several other challenges specific to New York State include poor quality control of health care and funding. In addition, there are the challenges of addressing the needs of inmates having mental health issues, HIV-AIDS, limited English language proficiency, and/or limited access to Medicaid.

Quality Control: Statewide, health care for the general prison population is uneven due to a lack of meaningful, coordinated quality control. A study of large jails conducted by the Centers for Disease Control and Prevention (CDC) identified "contextual factors" that affect the success of a public health model of correctional health care. Two of these are the bureaucratic complexity of the collaborating organizations and having a "champion" within the collaborating agencies. It is not clear where New York stands on these factors.

Funding: Health care within the New York State Department of Correctional Services (DOCS) is subsidized by the $50 million in commissions it receives from phone companies that are awarded lucrative prison phone contracts. Friends and family – largely from low-income communities -- who make phone calls to incarcerated persons are charged $1.00 per minute for collect calls; in turn, these fees are used to pay for correctional health care.

Mental health: Throughout New York and across the country, local correctional facilities and detention centers report an increase in the number of detainees with a serious mental illness, due in part to the lack or inadequacies of community-based mental health services. In fact, on an average day, between 15 and 50% of men entering local jails have a history of serious mental illness, rates two to three times higher than the general population. In addition, 75% of those with mental illness also have a substance abuse disorder, and are likely to stay incarcerated 4–5 times longer than similarly charged persons without mental disorders. Most of them have been charged with minor offenses.

Meanwhile, corrections staff and mental health practitioners fail to understand the limitations of each other's function, as well as similarities in what may appear to be different missions. The primary role of mental health staff is more than simply monitoring the facility, reporting abuse, or acting solely as an inmate advocate. Corrections officers and police who believe that a certain inmate requires inpatient psychiatric care may become frustrated when a clinician recommends a different course of action. Working through these differences in agenda and professional opinion is essential to improving collaboration, but is often difficult to achieve in the short-term.

HIV/AIDS: The New York State prison system has the highest percentage of HIV+ inmates of any state prison system in the country. Yet, the care of inmates with HIV/AIDS is uneven, the medical staff lack basic knowledge of HIV/AIDS, and inmates report having no idea how to get an HIV test. Despite a strong recommendation in 2000 by the Correctional Association of New York to distribute condoms to inmates, six years later the commissioner of the NY State Department of Corrections perceives widespread distribution of condoms a security risk because it allows people to smuggle drugs into prison as "little balloons." These and other security concerns demonstrate the challenges of curbing the spread of HIV/AIDS.

Limited English Language Proficiency: With over 7,000 Spanish-speaking inmates in the New York State prison system, there is a significant need for medical personnel who can give information and prescriptions in Spanish. However, the ability to speak and write in Spanish is another skill lacking among state correctional health care workers.

Medicaid: The Medicaid problem in New York manifests in a wait of 45 to 90 days after release for applications to be processed and to receive benefits. This poses serious problems for persons with chronic illnesses who are re-entering the community, and it could pose problems to the public health and safety of the community where there are substance abuse and mental health concerns.

Discharge planning does not accommodate the approximately 30,000 inmates released into the community each year. Except for HIV+ inmates who receive a month's supply of medication prior to release (often through Ryan White CARE Act funding), most inmates leave prison with little money and no access to health care in the community. This is particularly true for elderly inmates, and those with chronic conditions such as mental illness, heart disease or Hepatitis-C.

# BEST PRACTICES IN CORRECTIONAL HEALTH CARE

## Overview of Best Practices

Because the structure of correctional health care systems is so diverse it is difficult to precisely say what best practice is: one facility may be strong in one particular component while another one with almost identical dynamics flounders in this area. Besides the differences between jails and prisons, considerable variation exists within state correctional systems. It is clear, however, that the field of correctional health care is beginning to move closer to a public health model. While the widespread community benefits of the model may be an easier case to make to those concerned with jails, prison administrators and others on this side of correctional health care is beginning to see the value. For example, a forthcoming report from NCCHC on the health status of soon-to-be-released inmates strongly advocates that inmate health is the primary vehicle through which to address public health issues. While universal support by jails and corrections officials is not imminent, the field is gaining considerably more attention.

A public health or community-based model of correctional health care includes several key elements:

- **A clear mission statement** that places correctional health care firmly in the context of a community re-entry philosophy, and recognizes the incarcerated and ex-offenders as *displaced members of a community*.

- **Strong partnerships** that involve community health centers, departments of corrections, departments of public health, departments of mental health, hospitals and clinics, private providers, HIV/AIDS organizations, substance abuse treatment centers, mental health organizations, homeless shelters, representatives from the probation and parole components, social workers and case managers. Nonprofit community-based service providers, including faith-based providers, that address housing, education and training, labor force intermediaries, microenterprise organizations, are also important stakeholders. Colleges can play important roles as well: universities in conducting research and evaluation, and community colleges in designing and delivering training curricula.

- **Effective discharge planning** begins well in advance of release and continues during the post-release phase, and includes close interaction between the various correctional personnel involved in discharge planning and community partners, and attention to the sequencing of health care protocols and discharge.

- **Community involvement** through effective networks of nonprofit, community-based service providers capable of customizing programs and services to the particular needs and circumstances of target populations. Community organizations must have the capacity to build good relationships with correction personnel so that they are allowed to begin working with offenders before they are actually discharged. Successful continuity of care depends on: inmates and community organizations having personal contact and building a rapport before release; and the ongoing involvement of community organizations in discharge planning and implementation. This also implies that community providers have access and the means to travel to correctional facilities -- many of which are located far from local communities. Some correctional systems try to facilitate community involvement by moving inmates closer to their communities within 3-6 months of discharge, but this is not the norm.

- **Strong case management and outreach** that focuses on building relationships between health care providers, offenders, and their families and which begins at intake and continues well into the post-release phase.

- **Co-location of health practitioners** and case managers within community reporting centers and/or other facilities to which those on probation or parole must report, and the coordination of these services with community health centers. In these instances, because the nurse practitioner, for example, is an employee of the health center, privacy issues are protected. Moreover, the center may be able to bill for services that are reimbursed by Medicaid.

- **Operational support** that allows health care providers, correctional workers and community-based service providers to work across disciplines.

## SPECIFIC PROGRAMS

Several programs emerged repeatedly in discussions with key informants and are described below. They are the Hampden County (MA) Correctional Center (HCCC), the Community-Oriented Correctional Health Services (COCHS) program, the Morehouse Medical School (MMS), the National Commission on Correctional Health Care (NCCHC), and the re-entry programs run by Hampden County, and the states of Oregon and North Carolina.

### Hampden County Correctional Center: Public Health Model of Community Corrections

Hampden County Correctional Center's *Public Health Model of Community Corrections* continues to be the leading model to address correctional health care as a part of broader community health objectives. HCCC is a medium security jail located in the Springfield, MA region. Inmates at the facility are organized by zip code and assigned to neighborhood health centers. For many inmates, jail allows them to receive comprehensive medical services for the first

time. HCCC contracts with four community-based health centers, one of which is a not-for-profit center, two that are affiliated with large hospital systems, and a fourth which is a federal health center. Health practitioners are co-located at the jail and the health center and undergo joint training with correctional staff.

The health center has the requisite partnerships to address a broader palette of reentry support services beyond immediate health issues, such as housing, employment training, jobs, etc. HCCC's *After Incarceration Support System* (AISS) provides the operational framework through which correctional staff, health providers, volunteers and inmates work together to develop and implement transitional strategies, which continue into the probation and parole phases. In addition to mapping out a strategy that promotes continuity of care, this approach -- a partnership with the inmate -- helps community health centers reach family and community members who may be disconnected from health services. This is especially important given the impact that the incarceration of a family member has on the entire family. Brightwood Health Center, the flagship partner of HCCC, has a particularly strong community outreach mission that relies on partnerships with other community-based organizations and schools.

On the corrections side, much of HCCC's success is attributed to the strong leadership of the Hampden County Sheriff, who understands the interrelationships between effective re-entry strategies and community stability and the role of community-based correctional health care within this context. His lengthy tenure in his current position adds to his administrative and political capital to implement such an innovative program.

HCCC devotes considerable staff to its comprehensive health education program including a full-time staff Nurse Educator, Health Educator, HIV Educator, and HIV/AIDS Coordinator. Funding from the state public health department and private grants supports targeted education for identified conditions such as HIV/AIDS, Hepatitis-C, and diabetes. Staff and outside volunteers provide additional personnel for health education and prevention.

HCCC also has an in-house non-profit entity that serves as the fiscal conduit for grant funding. With this resource, HCCC is eligible for grants from public and private foundations that it may not receive as a governmental agency. HCCC also dedicates a full-time Sheriff's Department staff position to securing and managing outside grants. Many of the grants are written in collaboration with community partners to reduce duplication of services and to increase the likelihood of programmatic collaboration.

### Community Oriented Correctional Health Services (COCHS): Building on the HCCC Model

Despite an impressive track record, national awards, and peer recognition, not many correctional systems have attempted to replicate the HCCC model. The Robert Wood Johnson Foundation (RWJ) recently awarded Community Oriented Correctional Health Services (COCHS), a nonprofit policy research organization, $7.5 million over three years to expand the HCCC model nationwide. While sheriffs and correction officials may be resistant to moral arguments for innovative correctional health care approaches, they generally respond to strategies that ease their contracting processes and reduce costs -- aspects that made the proprietary systems easier to sell.

COCHS starts from the perspective of *jail as a place to provide health care* as opposed to just providing medical care, and sees jails as institutional partners in place-based public health strategies. It views jailed offenders as *community members who are temporarily displaced*. Its refinement of the HCCC model is designed to compete directly with proprietary systems, which will ultimately reduce costs, promote greater continuity of care, allow profits to be reinvested in community health objectives, and reestablish community health centers as drivers of community development and well being. COCHS will offer technical assistance to help jails develop partnerships with community health centers and other stakeholders, as well as address important components needed to take the model to scale, such as building the capacity of service providers and generating buy-in from potential community partners.

It is also devoting considerable attention to addressing information technology challenges that would make inmates' past, present, and future medical records available to health care providers anywhere within the correctional system. In addition to facilitating treatment of active medical conditions, this system would allow jail-based medical providers to have input on where and how an incoming offender should be confined. Records would be updated within 24 hours of receiving any medical attention, but would also include other relevant information that may affect health and well-being. Discharge planning details will be integrated into the records so that the history moves with the ex-offender. Under this model, in which the medical practitioners work for the community health center, the privacy of medical records is protected.

Because COCHS helps correctional systems to execute one contract instead of having to negotiate and manage multiple contracts with a variety of providers, it provides an alternative to the proprietary systems. COCHS will manage the subcontracting process with the array of providers, placing the community health center at the center of the organizational structure. COCHS will provide technical assistance to providers, community organizations, case managers and others partners and will help broker and manage the institutional relationships needed to implement this approach. This is one of the main differences from the HCCC model. Moreover, cost savings that would otherwise exit the community as profits under the proprietary model would be available instead to the community for broader health and social objectives.

Indications are that interest is growing in innovative approaches such as COCHS. Although it is only three months into operations it has received a number of unsolicited queries from public officials and correctional officials. COCHS recently began working with Washington, DC's correctional system. While many are undoubtedly drawn to it because it offers an easy contracting vehicle, its value lies in a commitment to health care as a right and its ability to position community health centers at the center of a community-driven health model that recognizes the role of jails in reaching and serving vulnerable populations.

## Morehouse Medical School

Morehouse Medical School (MMS) is a historically-black medical school located in Atlanta, GA. It has a legacy of community service, including work with the homeless and other under-served communities. It was drawn to correctional health care issues because of its inability to adequately serve men living in low-income African American communities, due in part to the disproportionate number of black men in the criminal justice system. It has made several important contributions to the field. MMS's Director of Community Voices and Associate Director of Development, Dr. Henrie Treadwell, edited the October 2005 issue of the American Journal of Public Health, which was devoted to correctional health care. One of MMS's objectives has been to advance a scientific framework and standards, particularly related to African American males. At the same time, it is developing outreach and treatment protocols and policy strategies around mental health, oral health and accessing Medicaid. MMS has convened specialists and practitioners, most recently in May 2006, where more details of the model were discussed. Its role in correctional health care is quite unusual for a medical school. MMS is interested in establishing a center to demonstrate the important role for medical schools in this field and is hoping to get support from the National Institute of Mental Health and other partners.

## National Commission on Correctional Health Care (NCCHC): Delivering Quality Care in the Prison Setting

Delivering chronic care services is perhaps the most pressing limitation to delivering quality care in the prisons. A number of practitioners have worked with the National Commission on Correctional Health Care (NCCHC) to develop guidelines and reporting systems that would aid in the delivery of common chronic disease management, including setting standards and a code of conduct for practitioners that would prevent them from ignoring chronic diseases in the correctional setting. With funding from the Robert Wood Johnson

Foundation, NCCHC is developing common forms, data entry systems, and protocols that ultimately increase quality control. In addition, the data system would allow tracking by multiple indicators -- by disease, patients, providers, etc. Widespread adoption of these guidelines and systems has yet to occur, perhaps due to a lack of resources to sufficiently market them. This is unfortunate given the importance of monitoring chronic disease processes and outcomes. One starting point to spur adoption is through the Association of Directors of Corrections, appealing to their interest to contain costs by instituting protocols that will ultimately reduce emergency visits, chronic interventions, morbidity, etc. Identifying correctional systems that may be willing to demonstrate these approaches may provide compelling incentives to others.

### Innovative Re-entry Models in Hampden County, Oregon, and North Carolina

A recent study by The National Commission on Correctional Health Care documents that few correctional health systems have developed coordinated transitional care planning programs that address the range of problems facing inmates returning home. The characteristics that distinguish the Hampden County, MA (cited above), Oregon, and North Carolina models are:

- A strong mission to prepare inmates for successful reentry
- Demonstrated leadership by both the correctional and health care agencies of consistent support for reentry preparation programs
- A holistic perspective to successful reentry
- A long-term commitment spanning at least five to ten years
- Deep institutional memory among program staff
- Commitment to re-entry and transitional health as manifested in program operating budgets
- Intensive re-entry planning and focus in the last three to six months before release

- Individual accountability by each inmate for his or her success upon returning home
- Geographic proximity of facilities to the communities where former inmates will return

The Turning Point Alcohol and Drug Treatment Program is located in the Columbia River Correctional Institution in Portland, OR. It houses fifty inmates who are dually diagnosed with mental illness and substance abuse and who are within six to fifteen months of completing their incarceration. Treatment includes intensive counseling, twelve-step programs, recovery skills, and symptom and medication management groups.

In the North Carolina Aftercare Planning in the Health Services program, the inmate, social worker and other members of the institutional treatment team create a detailed aftercare plan six months prior to release. The social worker provides detailed referrals to a variety of relevant agencies in the community where the soon-to-be-ex-offender will be released. Community based partners include the Duke University Medical Center, East Carolina School of Medicine, the University of North Carolina hospital system, the Veterans' Administration, community faith-based organizations, Alcoholics Anonymous and Narcotics Anonymous. Each person released gets a copy of aftercare planning forms, medical records, records of programs completed and personal identification cards (social security, driver's license, etc.).
In addition, several service providers in New York City offer notable re-entry programs:

- The Fortune Society offers residential and drop-in services, including HIV care

- The NYC Link – funded by the New York City Department of Health and Mental Hygiene -- offers short-term transitional case management for ex-offenders with persistent mental health illness

▪ The Osborne Association runs the AIDS in Prison and Risk Reduction Services Program, providing a hotline (in English and Spanish) to persons while they are incarcerated to plan for their discharge from prison. Eleven non-profit agencies work with Osborne to serve as a case management safety net;

▪ New York Therapeutic Communities runs the Stay 'N Out residential program to inmates with chemical dependencies; successful completion of the program leads to a referral to aftercare facilities; and

▪ The New York State Division of Parole trains select parole officers to serve parolees with mental illness

# PHILANTHROPIC OPPORTUNITIES IN CORRECTIONAL HEALTH CARE

## Current Philanthropic Involvement in Correctional Healthcare

According to Grantmakers In Health (GIH), the Council of Foundation Affinity Group of funders devoted to health and health care, not many funders can be identified as explicitly supporting correctional health care, nor does any particular type of foundation appear to support the issue more than others. Among those interviewed for this report, the general consensus is that while few foundations fund in this area, there is ample opportunity for private philanthropies to influence the field of correctional health.

Foundations do appear to be supporting correctional health care as part of other programming, such as comprehensive prisoner re-entry initiatives or juvenile justice programs. Some of the health funders have arrived at the issue

through programs that address mental health issues, substance abuse, and/or HIV-AIDS. A few funders looking for points of entry to meet the needs of vulnerable populations and stabilize at-risk communities recognize that jails are, indeed, community institutions and that the flow of people in and out of jails has community-wide impacts.

The Robert Wood Johnson Foundation, in particular, sees the connection between jails and community health centers as not only a way to ensure continuity of care for ex-offenders during the post-release phase, but as a means of improving access to health care in under-served communities through the social networks that exist between ex-offenders, their families, and community members.

There are other interesting examples of foundations that are finding ways to support correctional health care. For example, in Pittsburgh, a number of foundations interested in criminal justice have organized themselves into a type of funders collaborative. The group, Funders in Criminal Justice (FCJ), includes a number of private and family foundations, as well as the community foundation. FCJ is essentially an affinity group organized under the area's Regional Association of Grantmakers. Its members represent a range of program interests that intersect the field of correctional health care, from mental health and substance abuse, to issues related to children, family and youth of the incarcerated, to racial disparity issues. This group was largely responsible for getting the topic of correctional health care added to GIH's annual meeting in February 2006. Locally, FCJ has been instrumental in creating a number of specialty courts, including a drug court and a mental health court, which are now fully funded by public sources. The group meets monthly and has sponsored conferences, mapped the patterns of incarceration and re-entry in the region, and jointly funded projects. Most of the grantees supported by these funders provide direct services within the jails, particularly in mental health areas.

A number of funders have found their way to correctional health issues through their interest in mental health and well-being. For example, the Health Foundation of Greater Cincinnati's work in mental health has included over $600,000 in grants to address mental illness and substance abuse in the criminal justice system. In Texas, the Hogg Foundation for Mental Health funded the El Paso Public Defender's Office's efforts to develop an early assessment and referral model for defendants with mental illnesses. The UniHealth Foundation in Los Angeles has supported a comprehensive outpatient substance abuse program for HIV-positive, drug users who are being released from the county jail. The substance abuse treatment services are part of a comprehensive package of supports, including primary health care, aggressive case management, housing, and other social services. The Caring for Colorado Foundation underwrote the establishment of the *Corrections Ventline*, a 24-hour, anonymous telephone and email hotline for corrections staff and their families to help them address problems associated with the job and connect them with mental health resources. The Health Foundation of Central Massachusetts is working with community health providers and the Worcester County Sheriff's Office to offer parenting education to incarcerated and recently released fathers.

Similarly, funders working in juvenile justice have supported correctional health care projects. For example, The California Endowment has supported efforts in Pennsylvania to develop a health screening tool specifically for girls. This is in response to the rising number of girls who are entering juvenile justice systems, which were designed almost exclusively for boys and are poorly equipped to address the health and medical needs of girls. The foundation expects the screening tool to be adopted as a national standard. The Jessie DuPont Fund in Florida funded the National Council on Crime and Delinquency to work with the State of Florida to develop a continuum of care model for girls in the juvenile justice system. The Connecticut Health Foundation has provided support to Big Brothers/ Big Sisters to develop mentoring programs for children of incarcerated parents.

For its part, Grantmakers in Health plans to organize an audio conference on the subject of *prisoner re-entry and health* in fall 2006. This is in response to the emerging issues, and it would be in its capacity of providing technical assistance to health funders. These audio conferences allow interested funders to listen to and query experts and researchers in the field and offer an informal means of networking among interested foundations.

From a programming standpoint, the experience of The California Endowment in creating its Healthy Returns Initiative may be instructive. Healthy Returns is a four-year, five-site, $6 million initiative aimed at building the capacity of probation departments to effectively address the mental health needs of adolescents by improving access to services during detention and post-release continuity of care. The Endowment devoted approximately two years on the front end to design the initiative, during which time it engaged in an internal planning process, which was informed by the variety of stakeholders involved in the field. It also examined the work of other foundations, considered potential partners, attended and sponsored conferences, and commissioned white papers.

While the Healthy Returns Initiative has an overall objective of systems reform, its operational focus is on building the capacity of stakeholder organizations to work in partnership across disciplines and to demonstrate innovation and improvement in the field. The sites selected represent a mix -- urban, rural, and various ethnic and cultural compositions -- and overlap with the sites funded through the Annie E. Casey Foundation's juvenile justice initiative, thus, providing the California Endowment with a measure of quality control and return on investment. Four of the selected county probation departments will receive $950,000 over four years, (one site will receive a $250,000 one-year planning grant). The initiative proceeds from a one-year planning phase, followed by a three-year implementation phase. In this model capacity building is concomitant with implementation, as opposed to a separate phase.

Significantly, Healthy Returns recognizes the value and necessity of providing resources for evaluation. This is a matter of practice for The California Endowment, which routinely makes funding available within its grants to help grantees design internal evaluation plans, collect and analyze data, utilize the findings, and produce reports that improve internal programming and inform the field. For Healthy Returns, the Endowment has allocated approximately $700,000 for ongoing, cross-site evaluation and $800,000 for technical assistance, or about 25 percent combined, with added support for conferences and convenings.

## Overall Philanthropic Opportunities and Recommendations

A number of interviewees suggested that if private foundations are interested a community health-based approach to correctional health care they would logically find a way to support jail-focused initiatives. There are certainly fewer social and political barriers affecting health care delivery in jails, and the obvious ties to communities are considerable incentives. Barriers to working within prison systems include: geographic challenges; the bureaucratic complexity and politics associated with prison contracts; the difference in health care needs of those in jails (who tend to be younger) versus those in prisons (who tend to be older); and issues associated with public perceptions of prisoners as hardened criminals. Nonetheless, people working in jails face administrative and security barriers in gaining access to inmates, and many regional jails and houses of correction are administratively and culturally detached from communities and community organizations.

No matter where the focus of attention, however, foundations must remain mindful of the wide variety of conditions found within and across correctional systems. They must be willing to support strategies aimed at changing the culture of these institutions and challenging business-as-usual practices. Building support for innovative correctional health care models, particularly among corrections administrators is important, while at the same time overcoming strong public bias

against prisoners. However, few interviewees expressed much confidence that the public will accept increased resources for inmates without some sort of public awareness campaign, but this may not be the most effective use of foundation resources.

Several interviewees identified the importance of working with correctional administrators, public officials, and legislators as an effective way to begin to change perceptions about the importance of addressing correctional health care issues. Systems that provide responsive health services to inmates tend to have strong support from high levels. For example, the sheriff in Hampden County, MA has an extensive track record within that correctional system. He has provided strong leadership and amassed the political capital associated with a long, effective tenure to be able to implement innovative policies and programs. Identifying correctional and political administrators who are willing to address these issues and providing them with the resources and data to make the case should be an essential element of any funding strategy. This strategy element is dependent on having well developed, evidence-based data systems around which effective policies and programs can be designed.

Similarly, the same NCCHC study that highlights the Oregon, North Carolina, and Hampden County re-entry models states that replication depends on more rigorous measurement of their outcomes, effectiveness, and financing. Among the specific questions that need to be answered are the degree to which these model transitional programs achieve continuity of care for persons with chronic illnesses and disabilities. In addition, there are still questions about the impact of these models on families and communities, including subsequent social and health care costs. Each of these elements requires a degree of political and financial support that often is difficult to achieve.

## Specific Recommendations

Several pieces of state and national legislation provide an opening for foundations to promote greater replication of the public health model nationally and throughout the state of New York. In the New York State Assembly, four pending bills address mental health services, oversight of correctional health facilities, STD/HIV/HCV education and prevention programs, and transitional Medicaid benefits. At the federal level, the Second Chance Act of 2005 is re-entry legislation designed to ensure the safe and successful return of prisoners to the community. It allocates $110 million toward a variety of re-entry programs, and demonstration projects to provide ex-offenders with coordinated continuity of care in housing, education, health, employment, and mentoring services. The bill was introduced in 2005 in both the U.S. House (H.R. 1704) and Senate (S. 1934), and enjoys broad bipartisan support, including sponsorship by committee leaders in both chambers.

Within the context of greater national and state interest, below are **nine specific recommendations** for foundations interested in supporting correctional health care. The recommendations include:

1. Access to Medicaid funds
2. Data collection, research and evaluation
3. Capacity building
4. Policy advocacy and system reform
5. Training and technical assistance
6. Curricula development
7. Support services to families of offenders
8. Convening stakeholders
9. Gender-specific health care

1. Accessing and supplementing Medicaid funds - Lack of insurance is one of the biggest causes of gaps in health care. Foundations could play a valuable role in supporting advocacy networks to work with local governments to improve Medicaid enrollment or re-enrollment for ex-offenders and documenting best practices in this area. Additionally, because Medicaid is a bureaucratic system that is difficult to navigate, training support for case managers would also help, as would supporting aspects of model(s) that can not be recovered from Medicaid or other sources of public funding.

2. Data Collection, Research and Evaluation - The full potential of comprehensive correctional health care will not be realized or appreciated until the data gaps are filled. Without conclusive outcome studies that demonstrate the public health model of correctional health care, the field will not win the widespread support of health care professionals, corrections personnel, policy-makers and the general public.

There is a widely shared concern that the management information systems within correctional systems generally are inadequate to serve the objectives of a community-focused correctional health care model. Few correctional systems have the time and resources to develop effective systems. Developing information technology (IT) systems that will allow medical records to be accessible across the community-jail-community continuum is critical, as is the need to evaluate outcomes on incarcerated and post-release persons and impacts on communities and families tied to community health care models.

In addition, reliable data are essential for measuring return on investment. Since the correctional health care policy agenda is largely driven by evidence-based program outcomes rather than by a political or legislative action, there is a critical need to develop effective demonstrations that resonate throughout the widely diverse correctional systems. Foundations are positioned to support demonstration projects to develop good data systems, using local facilities to test these approaches and disseminating the results through statewide networks.

They can also play a valuable role in supporting independent research and evidence-based assessments, as well as documenting and disseminating best practices.

3. Capacity Building - Building the organizational infrastructure and capacity to carry out these models deserves serious attention. Leadership development, partnership and collaboration, and training of frontline workers and community volunteers all deserve attention, as does helping stakeholders within correctional health tell their stories. By working as genuine partners in the process (and avoiding being too directive with correctional and health professionals), foundations can help facilitate building stronger, more effective institutions.

4. Policy Advocacy and System Reform - One of the challenges facing correctional health is the lack of widespread advocacy at the local, state and national levels. Little capacity exists within community health programs or among case managers to add policy advocacy to their plates without additional resources. There is no specific position within the federal government's health care infrastructure officially representing correctional healthcare, despite the fact that it provides services to more than 2 million Americans. An effective strategy may be to create local policy groups that can incorporate the outcomes of effective programs into policy and system reform agendas that target public officials, administrators, policy makers, and legislators. Private foundations themselves may be well-positioned to advocate for more coherence in and support for the field of correctional health care; in addition, they can support local policy groups to do so.

5. Support for Training and Technical Assistance – Foundations can provide support for co-training of corrections and law enforcement personnel with crisis intervention teams, health and mental health practitioners, case managers, and others. Part of this includes developing protocols and delivering training to law enforcement officials so that people with mental health needs are taken to the

appropriate treatment facility, as opposed to being incarcerated in jail. In addition, foundations can support peer health education and prevention programs that help build trust and efficacy among inmates who may not trust government-funded health care providers.

6. Curricula Development – Foundations can support the development of training tools, including how-to basics, for medical personnel and other correctional health workers and administrators to orient them to working in correctional institutions. They also can help develop more extensive curricula for a series of courses on important topics such as management of chronic diseases, mental illness, suicide prevention, working with health departments, health care ethics, and so on.

7. Expand Support Services to Families of Offenders – By encouraging community-based organizations to get involved in delivering support services, foundations can expand services that are specifically designed for the families of people who are incarcerated. These families often face tremendous challenges at the outset and are extremely vulnerable once a family member is imprisoned. Developing interventions that address the needs of children and partners is critical. Connecting these families to community resources through community health centers within broader networks is essential to stabilizing these families, as well as integrating them into re-entry planning and preparing them to support the ex-offender during post-release. Among the services that foundations can support are broader language interpretation and translation services for people with limited English language proficiency.

8. Gender-specific health care - Comprehensive, integrated, gender-specific care is essential for the many inmates who suffer from both mental health and substance abuse problems. In particular, female inmates frequently have histories of physical and/or sexual abuse. Placement in mental health and/or substance abuse treatment programs – instead of incarceration – may be the

most effective way to address these problems and to reduce expensive incarceration costs.

9. Convening Stakeholders - The role of foundations as conveners has been vitally important to most successful programs and particularly to system reform initiatives, especially during the early stages. They have the power and influence to bring multiple stakeholders to the same table, which is very important given the lack of broad-based support for inmates and correctional health care. They can play a role in making a controversial topic safe for public consumption. Foundations can provide a forum for open dialogue and have the ability to facilitate broad information sharing as well. Equally important is the sway they have with each other and their ability to partner with each other in order to help bring initiatives to scale. This is vital to the success of community-oriented correctional health care strategies.

# Conclusion

States and municipalities struggle for the financial and human resources required for meeting basic correctional health care needs. While the decision-makers at many facilities understand the value of a public health model of correctional health care, they are challenged to expand their staff, organizational structures, institutional reach and core budgets beyond the basics. Limited federal and state resources are available to support correctional facilities. However, the greatest source of flexibility for creative, comprehensive correctional health care programming may be private foundations. Several models throughout the United States offer guidance for starting and sustaining such programs. Through the support of advocacy, research, education and training, private foundations can help correctional health care facilities improve dramatically the physical and mental health of incarcerated persons, while also protecting the public health of the general population. As this report attempts to demonstrate, the philanthropic opportunities are many.

## Works Cited


American Journal of Public Health. <www.ajph.org, v.95, no.10>

Anno, B. Jaye. Correctional Health Care: Guidelines for the Management of an Adequate Delivery System. Chicago, IL: National Commission on Correctional Health Care. 2001

Basic Prison and Jail Facts. New York, NY: Correctional Association of New York. 2004.

Burrell, Sue, and Alice Bussiere. The "Inmate Exception" and Its Impact on Health Care Services for Children in Out-of-Home Care in California. Youth Law Center. Woodland Hills, CA: The California Endowment, 2002.

Caring for the Incarcerated, Community Reentry and Health Policy: Searching for Common Ground (SCGP). Progress Report to the JEHT Foundation. National Commission on Correctional Health Care, 2005.

Charting the Safe and Successful Return of Prisoners to the Community. Report of the Re-entry Policy Council. Preview Report. New York, NY: Re-entry Policy Council. 2003.

Conklin, Thomas, Thomas Lincoln, and Rachel Wilson. A Public Health Model for Correctional Health Care: a Guide for Correctional Facilities to Put Public Health Services into Practice. Ludlow, MA: Hampden County Sherriff's Department. 2002.

Corrections Agency Collaborations with Public Health: Special Issues in Corrections. 2003.

Disciplinary Confinement in New York State Prisons. New York, NY: Correctional Association of New York. 2004.

Disciplinary Confinements in New York State Prisons. Chart. New York, NY: Correctional Association of New York. 2000.

DOCS Today 5th ser. 13. Albany,NY: New York State Department of Corrections. 2004.

Grantmakers in Health : Resource Center on Health Philanthropy. 2004. 24 Apr. 2006 <http://www.gih.org/info-url2764/info-url_show.htm?doc_id=49847>.

Health Care in New York prisons: A Report of Findings and Recommendations by the Prison Visiting Committee. New York, NY: Correctional Association of New York. 2000.

Hudson, Christie. Allegheny County Criminal Justice Resource Guide: Federal State, and Non-Local Foundation Funders of Criminal Justice Activities. Pittsburgh, PA: Funders in Criminal Justice. 2005.

Landsberg, Gerald, and Ann Smiley. Forensic Mental Health: Working with Offenders with Mental Illness. Kingston, New Jersey: Civic Research Institute, 2001.

Legislative Agenda for 2005-2006. Prison Visiting Project. New York, NY: Correctional Association of New York. 2005.

Mushlin, Michael B. Symposium: Prison Reform Revisited: The Unfinished Agenda.

National Corrections Demonstration Project. Centers for Disease Control. 24 Apr. 2006 <http://www.cdc.gov/nchstp/od/cccwg/default.htm>.

National Institute of Corrections Information Center

Potter, Roberto H., and Karina K. Rapposelli. "Large Jails and Communicable Disease: an Update on "Why Public Health Must Go to Jail"." Large Jail Network (LJN) Exchange. Washington, DC: National Institute of Corrections. 2002.

Prisoner Profile. Chart. New York: Correctional Association of New York. 2004.

Prisoner Re-entry: What are the Public Health Challenges? RAND Research Brief. Santa Monica, CA: RAND. 2003.

Prisoners in 2003. Washington, DC: Bureau of Justice Statistics, U.S. Department of Justice. 2004.

Prisoners in 2004. Chart. Washington, DC: Department of Justice Bureau of Justice Statistices, 2005.

Probation and Parole in the United States, 2004. Chart. Washington, DC: Department of Justice Bureau of Justice Statistics, 2005.

Profile of Jail Inmates. Chart. Washington, DC: Department of Justice Bureau of Justice Statistics, 2002.

Providing Mental Health Services in Local Detention/Correctional Facilities. New York, NY: New York State Office of Mental Health. 2000.

Re-Entry Trends in the United States. Chart. Washington, DC: Department of Justice Bureau of Justice Statistics, 2002.

Sherman, Francine T. Pathways to Juvenile Detention Reform. Juvenile Detention Reform and Girls: Challenges and Solutions. Baltimore, MD: The Annie C. Casey Foundation. 2005.

Solomon, Amy, etal. Outside the walls: A National Snapshot Of Community-Based Prisoner Re-Entry Programs. Washington, DC: Urban Institute and The Re-Entry National Media Outreach Campaign of Outreach Extensions. 2005.

Standards for Health Services in Correctional Institutions. Washington, DC: American Public Health Association. 2004.

Stanton, Glenn. Memo. Centers for Medicare and Medicaid Services, Center for Medicaid and State Operations, Disabled And Elderly Health Services Programs Group. Washington, DC: Department of Health and Human Services. 2004

Stanton, Glenn. Ending Chronic Homelessness. Centers for Medicare and Medicaid Services. Baltimore: U.S. Department of Health and Human Services, 2004.

The Unsolved Challenge of System Reform: the Condition of the Frontline Human Services Worker. Baltimore, MD: The Annie E. Casey Foundation, 2003.

Travis, Jeremy and Anna Sommers. Roundtable on Prisoner Re-Entry and Correctional Health Care. Journal of Correctional Health Care Vol. 10, No. 3

Trends in New York State Prison Commitments. Chart. New York, NY: Correctional Association of New York, 2005.

Walker, Claire. Children of Incarcerated Parents. Pittsburgh, PA: Pittsburgh Child Guidance Foundation. March 2005.

Women in Prison Project. Various fact sheets. New York, NY: Correctional Association of New York. 2005.

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